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AUTHOR Oakley, Suzanne J.
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ABSTRACT

Although long-term treatments have successfully reduced or eliminated the binging and purging of bulimia patients, there is a critical need for effective short-term treatments since many bulimics are college students who are not available for lengthy treatment. Seven female university students participated in an eight session individual cognitive-behavioral treatment designed to decrease the frequency of binge-purge episodes. The treatment focused on helping bulimics relax rigid controls over their eating and increase self-acceptance of their physical selves. Measures of restraint, body dissatisfaction, and frequency of binging and purging were employed to assess intervention effects. Repeated measures of these variables were taken and their course was plotted across the baseline, intervention, and one-month follow-up phases. At posttreatment there was a significant decrease in binging per week. By follow-up six subjects reported no binges. There was no statistically significant decrease in purging at either posttreatment or follow-up. At one-month follow-up, there was a significant decrease in restrained eating and body dissatisfaction. Intense concerns with weight, body shape, and dieting appear to persist after an improvement in frequency of binging and purging. At one-year follow-up, subjects continued to improve in eating behaviors and attitudes about weight and dieting: five subjects reported no binging for the month prior to the follow-up; none reported purging behavior. (Author/ABL)

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A Short-term Cognitive-Behavioral Approach to the Treatment of Bulimia

Suzanne J. Oakley, Ph.D.

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Seven female university students participated in an eight session individual cognitive-behavioral treatment designed to decrease the frequency of binge-purge episodes. The treatment focused on helping bulimics relax rigid controls over their eating and increase self-acceptance of their physical selves. Measures of restraint, body dissatisfaction, and frequency of bingeing and purging were employed to assess effects of the intervention. In addition, the change process was examined by taking repeated measures of these variables and plotting their course across the baseline, intervention, and one-month follow-up phases. At posttreatment there was a significant decrease in bingeing per week. By follow-up six subjects reported no binges. There was not a statistically significant decrease in purging at either the posttreatment or follow-up assessment. However, one of the two subjects who purged reported no purging by the eighth week of treatment. By the one-month follow-up assessment there was a significant decrease in restrained eating and body dissatisfaction. The predictions that a decrease in body image dissatisfaction and restraint would precede reductions in bingeing and purging were not supported. It appears that the intense concerns with weight, body shape, and dieting persist for some time after an improvement in frequency of bingeing and purging. A one-year follow-up was recently completed. Subjects continued to improve in both their eating behaviors and attitudes about weight and dieting. Five of the seven subjects reported no bingeing for the month prior to the follow-up. None reported purging behavior at the one-year follow-up.

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Treatment Rationale

Bulimia is often described as extremely persistent and difficult to treat with many of the reported interventions requiring months of therapy (Bauer, 1984; Fairburn, 1981; Loro, 1982). Typically these treatments address a variety of problems in addition to the eating behavior such as nonassertiveness, low self-esteem, and poor coping skills. Although these long-term multicomponent treatments have been successful in significantly reducing or eliminating the bingeing and purging, there is a critical need for effective short-term treatments since many bulimics are college students who are often not available for lengthy therapy.

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Two consistent findings that have emerged from the literature are that bulimics are chronic dieters and have a negative body image. There is evidence that the restrictive dieting behavior may be the primary problem. Survey studies have found a strong association between dieting and bingeing (Hawkins & Clement, 1980, 1984; Ondercin, 1979; Wardle, 1980), and clinical and experimental investigations indicate that binge eating may be a reaction to rigid dieting (Boskind-Lodahl & Sirlin, 1977; Bruch, 1973; Herman & Polivy, 1975; Spencer & Fremouw, 1979).

It has recently been suggested that a promising focus for treatment is to help bulimics reduce their dietary "restraint" (Polivy & Herman, 1983; Polivy, Herman, Olmstead, & Jazwinski, 1984; Wardle & Beinart, 1981). Restraint is defined as a behavioral and cognitive phenomenon involving resistence to pressures to eat (i.e., chronic dieting) as well as concerns about dieting and weight regardless of achieved success (Herman & Polivy, 1980). Experimental studies with "normal" restrained eaters (chronic dieters) suggest that excessive restraint increases the likelihood of bingeing in response to stress (Herman & Polivy, 1975), emotional upset (Baucom & Aiken, 1981; Polivy & Herman, 1976), or minor dieting violations (Polivy, 1976; Spencer & Fremouw, 1979). Negative emotional states and eating small amounts of "forbidden" foods are common precipitants of bingeing in bulimics. Reducing restraint entails helping bulimics relax their restrictive dieting behavior such that they increase the amount and variety of their daily food intake. In addition, the process of reducing restraint involves altering the negative body image which presumably supports the dieting behavior.

The purpose of the study was to examine the effects on bingeing and purging of a short-term, cognitive-behavioral treatment which focused

on reducing restrained eating. The treatment was designed to challenge the faulty thinking about body shape, control, and perfectionism exhibited by these young women. A major goal of therapy was to help the subjects to understand that contrary to their self-perceptions, their eating problems may be one of too much control rather than too little.

Two measures of restrained eating were used, the Eating Attitudes Test-26 (Garner, Olmstead, Bohr & Garfinkel, 1982) and a daily checklist in which subjects indicated whether or not they had attempted to diet that day. Measures of body image included the Negative Self-Image Scale (Nash & Ormiston, 1978) and a daily measure of the extent of critical thoughts about their bodies. The Eating Attitudes Test and Negative Self-Image Scale were administered at pretreatment, midtreatment (after the fourth session), posttreatment, one-month follow-up, and one-year follow-up. Subjects kept daily records of dieting behavior, negative thoughts, and bingeing/purging behavior throughout the baseline, intervention, and one-month follow-up phases.

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Treatment Summary

Session 1 Education About Bulimia and Introduction to the Cognitive-Behavioral Model

Education about the disorder included a description of the manifestations, estimates of prevalence, and the possible medical complications of chronic purging. The purpose of providing information on bulimia was to reduce subjects' sense of isolation and shame. The counselor explained the hypothesis that restrictive dieting may cause both physiological and psychological deprivation which in turn increases the likelihood of bingeing. The treatment approach was described as one which will help reduce both the restrictive dieting behavior as well as the intense concern with weight and dieting while at the same time encourage more self-acceptance of their body shape. Ellis' (1962) ABC sequence of antecedents, beliefs, and behavioral/affective consequences was presented by writing the sequence down on paper for the subject and giving examples of how beliefs about an event or situation affect our feelings or behavioral responses to the event. Subjects' records of binge/purge episodes were then used to illustrate the interaction between thoughts, feelings, and bulimic behaviors. The diet-binge-diet cycle was drawn and discussed with an emphasis on the cognitive factors involved in bingeing and dieting. For example, the counselor pointed out that the client engaged in dichotomous thinking when she stated her belief that she had to eat nothing or only unappetizing low-calorie foods because once she ate a small amount of a nondietetic food she had no choice but to binge. Subjects were encouraged to be aware during the next week of their thoughts and self-perceptions during each phase of the cycle. The counselor also instructed subjects to gradually increase the variety of foods they allowed themselves to eat, eat more regular meals, and weigh themselves less often as weighing may reinforce the preoccupation with dieting and body shape.

Session 2 Identification of Irrational Beliefs and Underlying Assumptions

Subjects' daily records were reviewed in order to further emphasize the relationship among behavior, feelings, and thoughts. Reported difficulties encountered in attempting to loosen controls over food intake were discussed. Often subjects attempted to drop all controls over their eating and this sudden lack of guidelines was frightening since they did not yet trust themselves to make reasonable food choices. The counselors advised subjects to make smaller changes in their diet initially until they were more comfortable with less restrictiveness. Counselors conducted a cognitive assessment of a recent binge episode in order to identify the beliefs and automatic thoughts that occurred before, during, and after the binge. Emphasis was given to identifying thoughts related to issues of control, perfectionism, and deprivation. Discussion about the possible basic assumptions (e.g. to be thin is to be in perfect control) that underlie the thoughts focused on the advantages and dis-

advantages of continuing to follow these assumptions. The counselors playfully challenged the assumption that perfect control is desirable or even possible and pointed out the emotional costs involved in striving for perfection. Subjects were encouraged to test the validity of their beliefs during the upcoming week by conducting "experiments" (Garner & Bemis, 1982). For example, the belief in the necessity of avoiding certain forbidden foods was tested by including small amounts of these foods in the daily diet and observing the effect on their weight and bingeing behavior. The counselor taught subjects how to challenge negative self-statements regarding weight-related appearance and eating behavior through modeling and rehearsal. For example, "I'm not disgusting simply because I ate a candy bar. I enjoyed the taste and this one candy bar is not going to make me fat."

Session 3 — Negative Self-Image

An exercise adapted from Orbach (1978) entails subjects drawing on newsprint their "fat" and "thin" selves complete with clothes, facial expressions, and hairstyle. Subjects then listed the feelings, behaviors, and personality characteristics associated with each body size. This exercise was used to increase awareness of the tendency to base personal worth on weight or body size. The assumption that one must be thin to be happy or successful was examined through questioning and discussion. Specifically, the counselor questioned why such qualities as sense of humor and intelligence should be associated with weight. Subjects were asked to specify the number of pounds that separated "fat me" from "thin me" in order to emphasize the arbitrary nature of the dichotomy. Subjects were instructed to observe or talk with others during the week to further check on the validity of their beliefs. For example, subjects were told to observe someone they admire or respect to determine how important weight is in comparison with the person's other attributes.

Session 4 — Negative Self-Image

Discussion focused on the results of the homework assignment and the perceived social pressures to diet. Bulimics frequently believe that their weight and physical appearance is being scrutinized by friends or family members. In an exercise designed to "decenter" (Garner & Bemis, 1982) and more realistically evaluate how their appearance affects others, subjects role played a significant other who is aware of their struggle with weight or food. The significant other gave his/her perspective on the situation and offered suggestions on what should be done. Following the role play, the perceived expectations and pressures from others were evaluated using the same methods that were applied to the subjects' irrational beliefs. Typically, however, subjects realized that the significant other did not see a problem with their weight and wished the subject would be less concerned. Subjects were encouraged to check out their perceptions with their significant others if possible, but the primary emphasis was on having subjects develop their own opinion as to what was an acceptable weight for them regardless of external pressures. If subjects anticipated criticism from a significant other regarding

their weight or eating habits, assertive replies such as "I can control my own eating" were practiced.

Session 5 Reduction of Dietary Restraint

The counselor explored subjects' diet and weight history to determine if subjects binged prior to dieting, if they gained weight when dieting, and if they had ever been able to maintain an acceptable weight without dieting. Since subjects' histories indicated it, the counselor suggested that the bingeing and preoccupation with food may be the result of too much control rather than too little. The relationship between dieting and the constant preoccupation with food was demonstrated via an exercise. Subjects were given the situation of walking past an ice cream parlor and deciding whether to buy some. For subjects who did not care for ice cream, a similar situation was given using their favorite food. In a role play (the gestalt empty chair technique), subjects alternately played the part of themselves that wants to eat and the part that attempts to exercise control. In processing the exercise, three key issues were addressed: a. the dichotomous thinking involved in labeling certain foods and eating behaviors as "good" or "bad", b. the beliefs and assumptions regarding the desirability of perfect control, and c. the tension and preoccupations generated by the struggle to avoid preferred foods. The counselor pointed out that dichotomous thinking is inherent in dieting and that preoccupations with food are characteristic of food-deprived individuals. Based on the subjects' internal dialogue played out earlier in the session, the counselor emphasized that the all-or-nothing approach to eating increases their susceptibility to bingeing when the subject cannot avoid food in her daily life.

Session 6 Reduction of Dietary Restraint

The counselor continued to focus on reducing dietary restraint. Subjects were encouraged to eat when hungry and to select food out of preference rather than according to external dieting "rules". Since most bulimics are not in touch with internal cues of hunger and satiety, counselors instructed subjects to become more aware of these cues prior to and during their eating. The counselors also recommended that before eating subjects spend some time determining what specific food(s) would be satisfying (e.g. hot or cold, salty or sweet, soft or hard, crunchy or creamy). A synopsis of the experimental research on restrained eating was presented to emphasize the point that chronic dieting may be counterproductive as it seems to increase the likelihood of bingeing in response to stress or negative emotional states.

Session 7 Reduction of Dietary Restraint

The counselor reinforced subjects' behavioral changes such as the inclusion of favorite foods into the daily diet and less rigid dieting. Further training was given in identifying and challenging dichotomous "diet" thinking and negative self-statements regarding weight and eating which interferred with subjects' ability to loosen their restrictive controls over food.

Session 8 Termination

The termination session included both the counselor's and subjects'

evaluation of the amount of progress made during the treatment. The counselor assisted subjects in developing plans for maintenance based on what aspects of the treatment subjects had found to be most beneficial and identifying other possible sources of support that could be used in the future.

EATING ATTITUDES TEST
(EAT—26)

Name:_____ Date:_____ Age:_____

Present Weight:_____ (lbs) Height:_____ Sex:_____

Highest Past Weight :_____ How Long Ago?_____

Lowest Past Adult Weight:_____ How Long Ago?_____

INSTRUCTIONS

Please place and (X) under the column which applies best to each of the numbered statements. All of the results **will be strictly** confidential. Most of the questions directly relate to food or eating, although other types of questions have been included. Please answer each question carefully. Thank you.

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	1.	Am terrified about being overweight.
☐	☐	☐	☐	☐	☐	2.	Avoid eating when I am hungry.
☐	☐	☐	☐	☐	☐	3.	Find myself preoccupied with food.
☐	☐	☐	☐	☐	☐	4.	Have gone on eating binges where I feel that I may not be able to stop.
☐	☐	☐	☐	☐	☐	5.	Cut my food into small pieces.
☐	☐	☐	☐	☐	☐	6.	Aware of the calorie content of foods that I eat.
☐	☐	☐	☐	☐	☐	7.	Particularly avoid foods with a high carbohydrate content(e.g. bread, rice, potatoes, etc.).
☐	☐	☐	☐	☐	☐	8.	Feel that others would prefer if I ate more.
☐	☐	☐	☐	☐	☐	9.	Vomit after I have eaten.
☐	☐	☐	☐	☐	☐	10.	Feel extremely guilty after eating.
☐	☐	☐	☐	☐	☐	11.	Am preoccupied with a desire to be thinner.
☐	☐	☐	☐	☐	☐	12.	Think about burning up calories when I exercise.
☐	☐	☐	☐	☐	☐	13.	Other people think that I am too thin.

ALWAYS	USUALLY	OFTEN	SOMETIMES	RARELY	NEVER		
☐	☐	☐	☐	☐	☐	14.	Am preoccupied with the thought of having fat on my body.
☐	☐	☐	☐	☐	☐	15.	Take longer than others to eat my meals.
☐	☐	☐	☐	☐	☐	16.	Avoid foods with sugar in them.
☐	☐	☐	☐	☐	☐	17.	Eat diet foods.
☐	☐	☐	☐	☐	☐	18.	Feel that food controls my life.
☐	☐	☐	☐	☐	☐	19.	Display self-control around food.
☐	☐	☐	☐	☐	☐	20.	Feel that others pressure me to eat.
☐	☐	☐	☐	☐	☐	21.	Give too much time and thought to food.
☐	☐	☐	☐	☐	☐	22.	Feel uncomfortable after eating sweets.
☐	☐	☐	☐	☐	☐	23.	Engage in dieting behaviour.
☐	☐	☐	☐	☐	☐	24.	Like my stomach to be empty.
☐	☐	☐	☐	☐	☐	25.	Enjoy trying new rich foods.
☐	☐	☐	☐	☐	☐	26.	Have the impulse to vomit after meals.

EAT - D.M. Garner and D.E. Garfinkel (1979) Toronto General Hospital, Toronto, Canada.

NSI

Name: _____

The items on this scale refer to your feelings about your body and physical appearance. There are no right or wrong answers so try to be completely honest in your answers. Read each statement carefully and circle the response which applies best for you.

1. I dislike seeing myself in mirrors.

   Never Sometimes Often Always

2. When shopping for clothes I am more aware of my weight problems and consequently I find shopping for clothes somewhat unpleasant.

   Never Sometimes Often Always

3. I'm ashamed to be seen in public.

   Never Sometimes Often Always

4. I prefer to avoid engaging in sports or outside activities because of my appearance.

   Never Sometimes Often Always

5. I feel somewhat embarassed about my body in the presence of someone of the opposite sex.

   Never Sometimes Often Always

6. I think my body is ugly.

   Never Sometimes Often Always

7. I feel that other people must think my body is unattractive.

   Never Sometimes Often Always

8. I feel that my family or friends may be embarassed to be seen with me.

   Never Sometimes Often Always

9. I find myself comparing myself to other people to see if they are heavier than I am.

   Never Sometimes Often Always

10. I find it difficult to enjoy activities because I am conscious about my physical appearance.

    Never Sometimes Often Always

11. My weight problem occupies most of my thinking.

    Never Sometimes Often Always

12. My thoughts about my body and physical appearance are negative or self-critical.

    Never Sometimes Often Always

Name: _____

Each day indicate whether you dieted by circling yes or no. Also, rate the extent to which you had self-critical thoughts by placing a check mark at the place on the scale which best reflects your experience.

Date	
	I dieted today. Yes No (circle one) I had negative or self-critical thoughts about my body today. : : : : : : None Constantly
	I dieted today. Yes No I had negative or self-critical thoughts about my body today. : : : : : : None Constantly
	I dieted today. Yes No I had negative or self-critical thoughts about my body today. : : : : : : None Constantly
	I dieted today. Yes No I had negative or self-critical thoughts about my body today. : : : : : : None Constantly

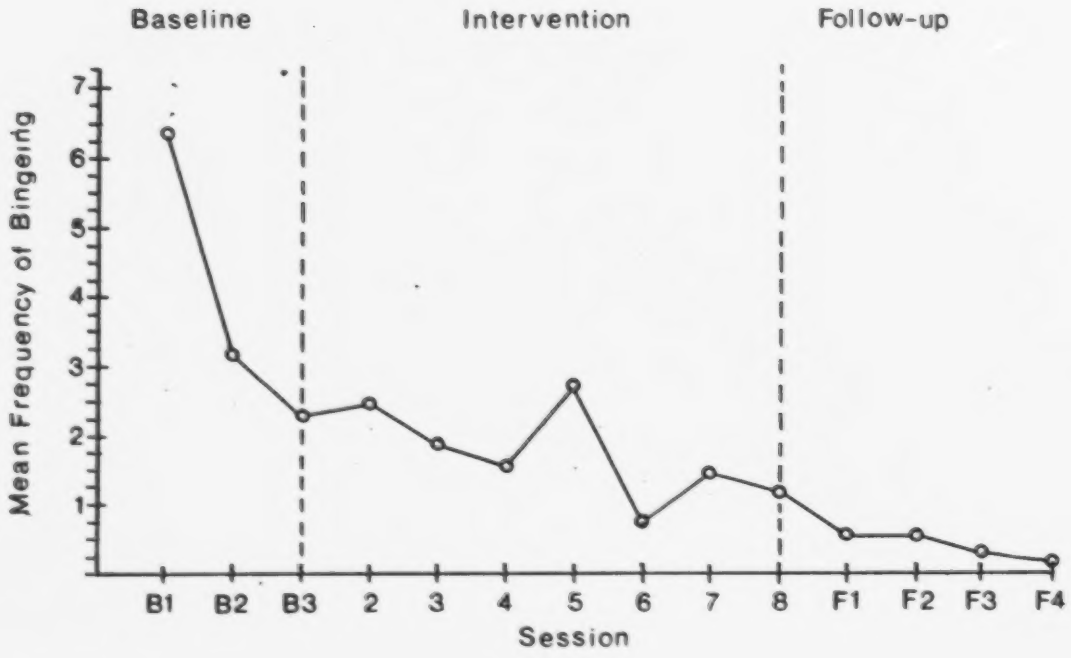
RECORD OF BINGE EATING AND VOMITING/PURGING EPISODES

Name: _____

DATE/TIME	BINGE	VOMITING	LAXATIVES	FEELINGS	THOUGHTS
				Before: During: After:	Before; During; After:
				Before: During: After:	Before: During: After:
				Before: During: After:	Before: During: After:

Figure 1

Mean Frequency of Bingeing for Seven Subjects Across Sessions



[a]N= 3 in 3-week baseline condition

HYPOTHESIS: A REDUCTION IN RESTRAINED EATING WILL RESULT IN DECREASED BINGEING AND PURGING

PROCEDURE:

* INDIVIDUAL COGNITIVE-BEHAVIORAL THERAPY WITH SEVEN BULIMIC WOMEN
* DAILY MEASURES OF DIETING, CRITICAL THOUGHTS ABOUT THEIR BODIES, AND BINGE/PURGE BEHAVIORS
* EATING ATTITUDES TEST-26 AND NEGATIVE SELF-IMAGE SCALE ADMINISTERED AT PRE, MID, POSTTREATMENT, ONE-MONTH FOLLOW-UP, AND ONE-YEAR FOLLOW-UP

TREATMENT:

SESSION 1 EDUCATION ABOUT BULIMIA AND INTRODUCTION TO THE TREATMENT MODEL. INSTRUCTED TO GRADUALLY INCREASE THE VARIETY AND AMOUNT OF FOODS IN DAILY DIET.

SESSION 2 IDENTIFICATION OF IRRATIONAL BELIEFS AND UNDERLYING ASSUMPTIONS REGARDING WEIGHT AND DESIRE TO BE THIN THROUGH COGNITIVE ASSESSMENT OF RECENT BINGE EPISODE.

SESSION 3 DRAWING AND DISCUSSION OF "FAT" AND "THIN" SELVES TO INCREASE AWARENESS OF TENDENCY TO BASE SELF-WORTH ON BODY SIZE OR WEIGHT.

SESSION 4 ROLE PLAY OF SIGNIFICANT OTHER IN ORDER TO MORE REALISTICALLY EVALUATE HOW OTHERS PERCEIVE THEIR APPEARANCE AND CONCERN WITH WEIGHT.

SESSION 5 ALTERNATELY ROLE PLAYED THE PART OF THEMSELVES THAT WANTS TO EAT AND THE PART THAT ATTEMPTS TO EXERCISE CONTROL TO EXPERIENCE THE TENSION GENERATED BY SUCH EXCESSIVE CONTROL. CHALLENGED DICHOTOMOUS THINKING INHERENT IN DIETING.

SESSION 6 RECEIVED SYNOPSIS OF RESEARCH ON EFFECTS OF RESTRAINED EATING. ENCOURAGED TO EAT OUT OF PREFERENCE RATHER THAN ACCORDING TO RULES.

SESSION 7 REINFORCEMENT OF REDUCTION IN RESTRAINED EATING BEHAVIOR. FURTHER TRAINING IN CHALLENGING DICHOTOMOUS THINKING AND NEGATIVE SELF-STATEMENTS CONCERNING WEIGHT, BODY SHAPE, OR EATING BEHAVIOR.

SESSION 8 TERMINATION. EVALUATION OF PROGRESS AND DEVELOPMENT OF PLANS FOR MAINTENANCE.

OUTCOME: AT POSTTREATMENT THERE WAS A STATISTICALLY SIGNIFICANT DECREASE IN BINGE EPISODES PER WEEK. BY THE ONE-MONTH FOLLOW-UP ASSESSMENT SIX SUBJECTS REPORTED NO BINGES. THERE WAS NOT A STATISTICALLY SIGNIFICANT DECREASE IN PURGING AT EITHER THE POSTTREATMENT OR ONE-MONTH FOLLOW-UP. HOWEVER, ONE OF THE TWO SUBJECTS WHO PURGED REPORTED NO PURGING AFTER THE EIGHTH WEEK OF TREATMENT. BY THE ONE-MONTH FOLLOW-UP THERE WAS A SIGNIFICANT DECREASE IN RESTRAINED EATING AND BODY DISSATISFACTION AS MEASURED BY THE EAT-26 AND THE NSI, RESPECTIVELY. AT THE ONE-YEAR FOLLOW-UP SUBJECTS REPORTED ADDITIONAL IMPROVEMENTS IN BOTH THEIR EATING BEHAVIORS AND ATTITUDES ABOUT WEIGHT AND DIETING. FIVE OF THE SEVEN SUBJECTS REPORTED NO BINGEING FOR THE MONTH PRIOR TO THE FOLLOW-UP AND NONE REPORTED PURGING. THE RESULTS INDICATE THAT REDUCING RESTRAINT IS AN EFFECTIVE AND EFFICIENT METHOD OF TREATING BULIMIA.

Figure 4

Frequency of Purging Across Sessions

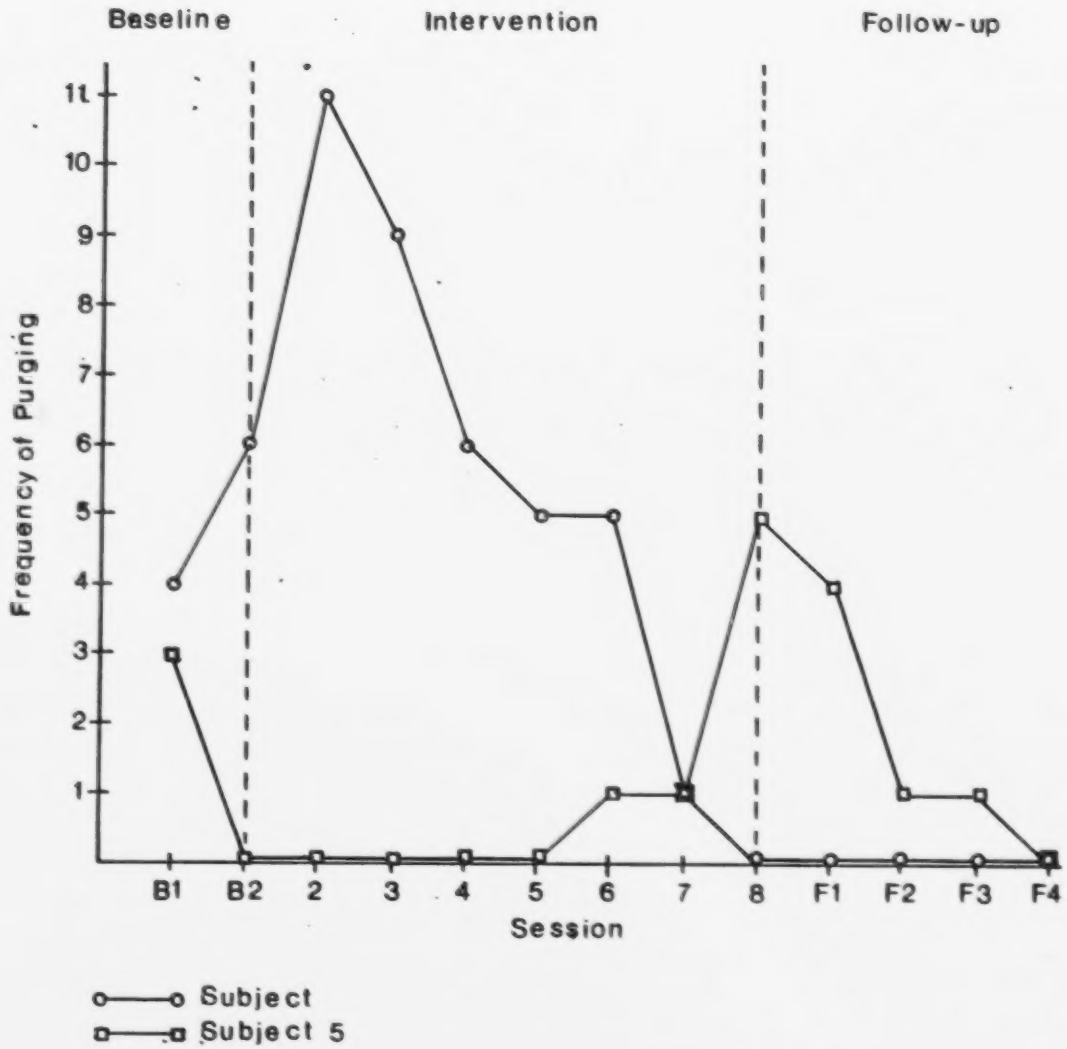


Table 1

Means and SD for Dependent Measures
Across Assessment Periods

Measure		Pre	Mid	Post	Follow-up
Bingeing	M	3.19	1.71	1.00	.14
	SD	1.88	2.98	1.73	.38
Purging*	M	3.25	3.00	1.50	.00
	SD	2.47	4.24	2.12	.00
Dieting	M	5.19	3.57	4.00	1.28
	SD	2.45	3.36	2.83	1.60
EAT-26[a]	M	28.43	28.00	17.57	11.71
	SD	11.82	13.99	10.71	7.39
Negative Thoughts	M	4.46	3.75	3.57	2.96
	SD	1.49	2.00	1.14	1.03
NSI[b]	M	21.71	22.00	17.57	16.14
	SD	5.68	8.39	7.48	7.06

[a]EAT-26 - Eating Attitudes Test-26

[b]NSI - Negative Self-Image Scale

*N = 2

Individual Scores on the EAT-26 and NSI Across Assessment Periods

Measure	Subject	Pre	Mid	Post	One-month Follow-up
Eating Attitudes Test-26	1	30	35	32	24
	2	51	51	31	8
	3	33	19	10	19
	4	14	19	18	11
	5	21	33	18	9
	6	28	31	10	9
	7	22	8	4	2
Negative Self-Image Scale	1	25	28	27	25
	2	29	32	19	18
	3	23	22	19	24
	4	12	13	11	9
	5	21	22	24	15
	6	25	28	18	16
	7	17	9	5	6

One-Year Follow-Up Data

Subject	EAT-26	NSI	Binge/Purge past month	Binge/Purge past week
1	4	6	0/0	0/0
2	10	13	12/0	3/0
3	5	14	0/0	0/0
4	1	7	2/0	0/0
5	10	19	0/0	0/0
6	1	9	0/0	0/0
7	5	9	0/0	0/0

Scores above 20 on the EAT-26 are indicative of an eating disorder. There are no well-established norms for the NSI; however, a score of 12 is considered average for noneating disordered women.